June 3, 2014

The Honorable Kevin Brady
Chairman
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Jim McDermott
Ranking Member
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Brady and Ranking Member McDermott:

On behalf of nearly 38 million AARP members and the millions more Americans with Medicare, thank you for holding the May 20, 2014, hearing examining current hospital issues in the Medicare program. Decisions concerning inpatient admissions, observation status, and short inpatient hospitals stays have a tremendous impact on Medicare beneficiaries. Specifically, the decision to admit an individual, and the timing of that decision, greatly affects the beneficiary's out-of-pocket costs and the ability to receive skilled nursing facility (SNF) care covered by Medicare.

The use of "observation status" has become more prevalent in recent years. A study released last year by AARP's Public Policy Institute found the use of Medicare hospital observation services grew by over 100 percent from 2001 to 2009.[i] This rise in observation services has coincided with a decrease in inpatient admissions. Additionally, the duration of observation stays has grown longer. While there may be several reasons for these trends, it is clear that Medicare beneficiaries are spending more and more time in the hospital without being formally admitted. Admission as an inpatient activates Medicare Part A cost-sharing and a three-day stay requirement; as opposed to observation status, which is billed under Part B and can expose beneficiaries to unexpectedly high out-of-pocket costs that can amount to thousands of dollars.

Two-midnight Rule

The Centers for Medicare & Medicaid Services (CMS) attempted to reduce the number of long observation stays by establishing a presumption that stays spanning more than two midnights would be considered medically necessary. In theory, CMS expects that deeming an admission reasonable and necessary if the stay is expected to span two midnights encourages providers to move some patients from outpatient or observation status to inpatient status.

CMS subsequently clarified that the two-midnight benchmark is not the *sole* criteria for admission. CMS believes that the two-midnight benchmark should not preempt physician judgment regarding medical necessity. Some patients may require hospital

admissions for less than two midnights, and physicians should not be discouraged from admitting them due to confusion or misinterpretation of the rule.

Cost-sharing

The two-midnight rule, however, fails to address how observation status affects beneficiary cost-sharing and SNF coverage. CMS expects the physician's decision to admit will be based on the cumulative time spent at the hospital beginning with the initial outpatient service, thereby allowing the physician to consider the time already spent receiving those services in estimating the beneficiary's total expected length of stay.

Yet, later in the rule, CMS states: "While outpatient time may be accounted for in application of the two-midnight benchmark, it may not be retroactively included as inpatient care for skilled nursing care eligibility or other benefit purposes. Inpatient status begins with the admission based on a physician order." (78 Fed. Reg. 50950) This appears to be a significant inconsistency which will have a dramatic impact on beneficiary costs. If the entire time spent receiving care is deemed reasonable and necessary for admission, then the entirety of care should be billed under Part A. Otherwise, CMS and the hospital are effectively telling the patient: "Some of the time you were here was reasonable and necessary and billed under Part A; yet, at the same time, some of the stay wasn't reasonable and necessary and will be billed under Part B." We believe CMS cannot have it both ways.

Billing for physician services, laboratory tests, imaging, and hospital administered drugs under Part B subjects the beneficiary to the 20 percent coinsurance. In addition, because Part B does not cover the cost of self-administered drugs provided in the outpatient setting, beneficiaries are typically responsible for the full cost of hospital charges for these drugs, instead of having them covered as part of a Part A stay. These charges can quickly add up and exceed the Part A hospital deductible amount of $1,216 per benefit period, as well as be especially burdensome for those on fixed incomes. We urge Congress and the Administration to clarify beneficiary cost-sharing for observation stays should align with Part A cost sharing upon admission.

Three-day Stay Requirement, Observation Status, and Skilled Nursing Facility Coverage

Individuals in observation status or observation (receiving outpatient observation services) are classified as hospital outpatients, not as inpatients. However, in many hospitals, actual medical services provided in the inpatient and observation settings are virtually identical. Patients in observation status may stay in a hospital bed overnight or for periods of time as long as several days and receive care that may be indistinguishable from inpatient care.

Unfortunately, the financial impact for Medicare beneficiaries who spend time in observation can be burdensome and significant. Medicare requires a three-day inpatient hospital stay as a precondition for Medicare coverage of SNF services. However, time spent in observation does not count toward the three-day stay

requirement, so some beneficiaries may fail to qualify for Medicare coverage of SNF care, even though they have spent more than three days in a hospital setting. These beneficiaries may be faced with paying the full cost of their SNF care or being denied appropriate SNF care due to lack of Medicare coverage. The Office of the Inspector General of the U.S. Department of Health and Human Services found that in 2012, Medicare beneficiaries who did not qualify for Medicare coverage of SNF services were liable for SNF costs averaging $10,503.[ii] In some cases, Medicare beneficiaries may not even be aware that they are under observation and the financial implications of observation status until after they leave the hospital. And those who are made aware of their observation status may forego necessary follow-up SNF care.

AARP and many other groups have endorsed the bipartisan Improving Access to Medicare Coverage Act (H.R. 1179/S. 569) sponsored by Representatives Joe Courtney (D-CT) and Tom Latham (R-CT) and Senators Sherrod Brown (D-OH) and Susan Collins (R-ME) to help address the high costs that some Medicare beneficiaries pay for SNF care due to their time in observation. This legislation would count time spent receiving outpatient observation services (i.e. in observation status) toward the 3-day prior inpatient stay requirement for SNF coverage. This legislation would help some beneficiaries receive the SNF services they need and help reduce large out-of-pocket expenses for some Medicare beneficiaries who need SNF services. We urge the House and Senate to act on this legislation.

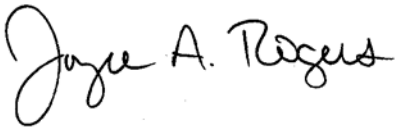
Prescription Drug Coverage during Observation Status

Many beneficiaries find themselves facing large hospital bills for drugs they received while in "outpatient" observation status. When an individual is in outpatient observation status at a hospital, Medicare Part B is billed, and pays for, 80 percent of the hospital services provided. However, some outpatient prescription drugs received in the hospital while a patient is in observation status, such as oral medications, are not billed to Part B. Beneficiaries who do not have Part D drug coverage must pay out-of-pocket for the full amount of hospital charges for these drugs. Beneficiaries who are fortunate enough to have Part D coverage must submit a claim to their Medicare Part D plan to receive reimbursement for these drugs. Part D plans are required to have a process in place to pay claims submitted by beneficiaries who received drugs from a hospital's out-of-network pharmacy. However, the burden falls on beneficiaries to get their drugs appropriately covered under Part D.

Beneficiaries must request an out-of-network pharmacy claim form from their Part D plan and submit the completed claim form with the bill for medications from the hospital as well as a letter explaining that they were in observation status at the hospital and could not get to an in-network pharmacy. If the beneficiary received drugs in the hospital that were off-formulary, they need to ask the Part D plan for an exception to have the drugs covered. Also, after the Part D plan covers the drugs, the beneficiary will be liable for co-pays which may be higher because the hospital pharmacy is out-of-network. In short, observation status is leading to higher drug costs for beneficiaries than they would otherwise incur if they received their drugs on an inpatient basis.

AARP appreciates the attention the Subcommittee is paying to observation stays and related issues. We look forward to working with the Committee as you address these issues and urge action on the Improving Access to Medicare Coverage Act. If you have any questions, please feel free to contact me or have your staff contact Andrew Scholnick or Rhonda Richards of our Government Affairs staff at 202-434-3770 or ascholnick@aarp.org or rrichards@aarp.org.

Sincerely,



Joyce A. Rogers
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Government Affairs

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[i] L. Zhao, C. Schur, N. Kowlessar, & K. Lind, *Rapid Growth in Medicare Hospital Observation Services: What's Going On?* 1 (AARP PPI, 2013), *available at http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/2013/rapid-growth-in-medicare-hospital-observation-services-AARP-ppi-health.pdf.*

[ii] Office of Inspector General, *Hospitals' Use of Observation Stays and Short Inpatient Stays for Medicare Beneficiaries," Memorandum Report OEI-02-12-00040* 15 (Office of Inspector General, Department of Health and Human Services, July 29, 2013), *available at* http://oig.hhs.gov/oei/reports/oei-02-12-00040.pdf.